

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with forms PM3, Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201																	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH																	
1. DECEASED-NAME (Type or Print)			First ERMA			Middle LEANNA			Last ASHBY			2a. DATE KNOWN <input checked="" type="checkbox"/> Month Day Year OF ESTI- DEATH MATED <input type="checkbox"/> June 29 1968		2b. HOUR 7:40 P.M.			
3. SEX Female		4. RACE White		5. DATE OF BIRTH 10/21/09		6. AGE (in years last birthday) 58 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN		2c. DATE PRONOUNCED DEAD Month Day Year June 29 1968		2d. HOUR 7:40 P.M.			
7a. BIRTHPLACE (State or foreign country) West Virginia				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. COUNTY OF DEATH Harford					
10. CITY OR TOWN OF DEATH Havre de Grace				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Harford Memorial Hospital				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Nurse				12b. KIND OF BUSINESS OR INDUSTRY Hospital					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland				13b. COUNTY Harford				13c. CITY OR TOWN Havre de Grace				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 2545 Old Robin Hood Road			
14. FATHER'S NAME First Middle Last Walter Swecker (Dec)				15. MOTHER'S MAIDEN NAME First Middle Last Lina Hogan													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 235-30-2986				17. INFORMANT ADDRESS Barbara A. Kelley, Havre de Grace, Maryland									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple injuries 8199 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 2254																	
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 6-29 1968				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) Auto Accident									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) US Route 40				21f. LOCATION Street or R.F.D. No. City or Town County State Robin Hood Rd. Havre de Grace Harford Md.									
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , (Inspection <input checked="" type="checkbox"/>) (Inquiry <input checked="" type="checkbox"/>) and in my opinion death resulted from: Natural causes <input type="checkbox"/> , (Accident <input checked="" type="checkbox"/>) Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>																	
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Gerald C. Palmer, M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, city, town, or county) Bel Air, Maryland				22b. DATE SIGNED 6-29-68									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE 3 July 68		23c. NAME OF CEMETERY OR CREMATORY Harford Memorial Gardens, Aberdeen, (Harford) Maryland				23d. LOCATION (City or Town) (County) (State)							
24. FUNERAL DIRECTOR Walter McCowan Sr.				Tarring Funeral Home Aberdeen, Md. 21001				25a. REC'D BY REGISTRAR JUL - 3 1968				25b. REGISTRAR'S SIGNATURE Charles Judge					

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

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MEDICAL CERTIFICATION

1. DECEASED-NAME (Type or Print) RICKY		First LOUIS		Middle LOUIS		Last CREGAR		2a. DATE KNOWN OF ESTI-DEATH MATED <input type="checkbox"/> Month <input type="checkbox"/> Day <input type="checkbox"/> Year 6-11-68		2b. HOUR M		
3. SEX M		4. RACE W		5. DATE OF BIRTH 24 Jan. 1954		6. AGE (In years last birthday) 14 YRS.		IF UNDER 1 YEAR MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/>		IF UNDER 24 HRS HOURS <input type="checkbox"/> MIN <input type="checkbox"/>		
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Harford						
10. CITY OR TOWN OF DEATH Harford				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Harford Memorial Hospital				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Student		12b. KIND OF BUSINESS OR INDUSTRY N/A		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland				13b. COUNTY Harford		13c. CITY OR TOWN Aberdeen		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 301 Custis Street		
14. FATHER'S NAME First Edgar Middle R. Last Cregar				15. MOTHER'S MAIDEN NAME First Norma Middle Hughes Last Hughes								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16b. SOCIAL SECURITY NO. N/A		17. INFORMANT ADDRESS Norma Dubree, Aberdeen, Maryland						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Decapitation 8199 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) 8254												
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year HOUR A.M. 19 P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) Auto Accident						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) HS 40		21f. LOCATION Street or R.F.D. No. Harford City or Town Harford County Harford State Md.								
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion												
ACTUAL SIGNATURE Gerald C Palmer				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED 6-12-68				
EXAMINER'S NAME (Type) Gerald C Palmer MD				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				ADDRESS (Street, city, town, or county) Bel Air, Maryland				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 14 June 68		23c. NAME OF CEMETERY OR CREMATORY Bel Air Memorial Gardens				23d. LOCATION (City or Town) (County) (State) Bel Air (Harford) Maryland				
24. FUNERAL DIRECTOR Thelma Wocaulin Esq.						25a. REC'D BY REGISTRAR JUN 17 1968		25b. REGISTRAR'S SIGNATURE Charles Young				



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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 1-1-68
30M REV 7/68

08499												
1. DECEASED-NAME (Type or print) First Middle Last						2a. DATE OF DEATH Month Day Year			2b. HOUR			
Charlotte Virginia Bass						June 4			68 9 ³⁰ M			
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
Female		White		24 January 1917			51 YRS.					
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH			
Md.			USA						Harford Md.			
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY	
Havre de Grace				Harford Memorial Hosp				Housewife			Home	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER		
Md.				Harford		Aberdeen		YES		172 Darlington Ave.		
14. FATHER'S NAME First Middle Last				15. MOTHER'S MAIDEN NAME First Middle Last								
James Raymond Meredith				Margaret Draper				(D)(C)				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)				16b. SOCIAL SECURITY NO.		17. INFORMANT Address						
No				217-16-3440		Otis W. Bass, Aberdeen, Maryland						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												
PART I. DEATH WAS CAUSED BY:												
IMMEDIATE CAUSE (a) Hypo-static Pneumonia												
DUE TO, OR AS A CONSEQUENCE OF												
(b) Hepatic Failure												
DUE TO, OR AS A CONSEQUENCE OF												
(c) Embolus of Liver												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)												
5810 (1) Fracture of Hep - healed 2 months prior to death												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
		19										
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)				21f. LOCATION Street or R.F.D. No.		City or Town		County State		
22a. I certify that (I) (this hospital) attended the deceased from 5-24, 1968, to 6-4, 1968, that (I) (we) lost saw the deceased alive on 6-4, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE						DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED		
Irvin L. Waschman, M.D.										6/5/68		
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS										
		Irvin L. Waschman, M.D.				Havre de Grace, Maryland						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)					
Burial		7 June 1968		Spesutia Cemetery			Perryman, (Harford) Maryland					
24. FUNERAL DIRECTOR ADDRESS						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
Tarring Funeral Home, Aberdeen, Md. 21001						DATE JUN 10 1968		Charles Judge				

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MEDICAL CERTIFICATION

08495				DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				08500			
1. DECEASED-NAME (Type or print)				First	Middle	Last	2a. DATE OF DEATH				2b. HOUR
WILLIAM				ROY	BRADLEY	JUN 4 1968				1050A M	
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.
Male		Cau		23 July 1889			78 YRS.		MONTHS	DAYS	HOURS MIN.
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		9. COUNTY OF DEATH		10. CITY OR TOWN OF DEATH			
Kansas		USA		NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		Harford		Aberdeen PG, Md			
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		13a. CITY OR TOWN		13b. INSIDE CITY LIMITS?		13c. STREET AND NUMBER	
US Kirk Army Hospital		Retired Soldier				San Antonio		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		2426 Blossom Drive	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address	
First Middle Last William John Bradley		First Middle Last Jenny Belle Luyster		Yes (No, na, or unknown) <input checked="" type="checkbox"/> 1919-1949		457-64-7407		Nancy Sheely, RFD 1, Box 18A, Whiteford, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatosis</u>										6 months	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>adenocarcinoma of the colon</u>										7 months	
(c) _____											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
<u>1538 Diabetes mellitus</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
Nov 1967		carcinoma of the colon		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		NO					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
		HOUR A.M. Month Day Year P.M. 19									
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION		Street or R.F.D. No.		City or Town		County State	
While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work											
22a. I certify that (I) (this hospital) attended the deceased from <u>3 May</u> , 19 <u>68</u> , to <u>4 June</u> , 19 <u>68</u> , that (I) (<u>we</u>) last saw the deceased alive on <u>4 June</u> , 19 <u>68</u> and that in (my) (<u>our</u>) opinion death occurred on the date and hour and from the causes stated above, (I) (<u>we</u>) (<u>did</u>) (<u>did not</u>) view the body after death.											
22b. SIGNATURE				22c. DATE SIGNED				22d. PHYSICIAN'S NAME (Type)			
<u>William M Stein, M.D.</u>				4 June 68				<u>william M STEIN</u>			
22e. ADDRESS				22f. ADDRESS				22g. ADDRESS			
<u>Kirk Army Hospital, APG Md.</u>				<u>Kirk Army Hospital, APG Md.</u>				<u>Kirk Army Hospital, APG Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)	
Burial		June 8, 1968		Sunset Memorial Park		San Antonio, Texas					
24. FUNERAL DIRECTOR				25a. REC'D BY REGISTRAR				25b. REGISTRAR'S SIGNATURE			
John H. Harkins, Delta, Penna.				DATE JUN 10 1968				<u>[Signature]</u>			

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VR 415 (4)
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) Norman T. Burkandine		2a. DATE OF DEATH Month 6 Day 20 Year 68		2b. HOUR 4:45 PM	
3. SEX Male	4. RACE White	5. DATE OF BIRTH 10/17/1910	6. AGE (In years last birthday) 57 YRS.	IF UNDER 1 YEAR MONTHS 0 DAYS 0	IF UNDER 24 HRS. HOURS 4 MIN. 45
7a. BIRTHPLACE (State or foreign country) MD	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Harford Md.		
10. CITY OR TOWN OF DEATH Harre-de-Grace	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Harford Memorial Hospital - Main Entrance	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) U.S. Govt.	12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD	13b. COUNTY Harford	13c. CITY OR TOWN Oberdeen	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER Grace Ford Dr. #26	
14. FATHER'S NAME First Frederick Middle Burkandine Last Stewart	15. MOTHER'S MAIDEN NAME First Emma Middle Stewart Last Stewart				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown no (If yes give war or dates of service)	16b. SOCIAL SECURITY NO. 215-05-0790	17. INFORMANT Name Evelyn S. Burkandine Address 20 Grace Ford Drive Aberdeen Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 5718 Portal Cirrhosis advanced DUE TO, OR AS A CONSEQUENCE OF (b) with massive ST Kerner's DUE TO, OR AS A CONSEQUENCE OF (c) 2 days Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 yr		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 5810					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. 19 Month 6 Day 20 Year 68 P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) 214		21f. LOCATION Street or R.F.D. No. 414 City or Town Harford County Harford State MD	
22a. I certify that (I) (this hospital) attended the deceased from 6/20/68 to 6/20/68 , that (I) (we) last saw the deceased alive on 6/20 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE W H Sadowsky MD		DEGREE MD ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 6/20/68	
22d. PHYSICIAN'S NAME (Type) W H SADOWSKY		22e. ADDRESS 504 LEWIS ST. Harre-de-Grace			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 6/23/1968		23c. NAME OF CEMETERY OR CREMATORY St Paul Lutheran	
24. FUNERAL DIRECTOR Walter Macomber Jr. Tarrington		ADDRESS Walter Macomber Jr. Tarrington		25a. REC'D BY REGISTRAR JUN 24 1968	
				25b. REGISTRAR'S SIGNATURE Charles Judge	

1038

REPUBLIC OF IRAN

00480



The main body of the document contains several paragraphs of text, which are extremely faint and illegible due to the quality of the scan. The text appears to be organized into a structured format, possibly a report or a letter, with distinct sections separated by lines or paragraphs. The overall appearance is that of a historical or official document that has been poorly preserved or scanned.

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VR A15 (4)
30M REV. 1/58

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

08497

08502

1. DECEASED-NAME (Type or print) <i>Charles Brittingham Burns</i>			2a. DATE OF DEATH Month <i>June</i> Day <i>6</i> Year <i>1968</i>			2b. HOUR <i>5:53</i> MIN <i>A</i>				
3. SEX <i>MALE</i>		4. RACE <i>white</i>		5. DATE OF BIRTH <i>MAY 15-1879</i>		6. AGE (In years last birthday) <i>89</i> YRS.		IF UNDER 1 YEAR MONTHS <i></i> DAYS <i></i> IF UNDER 24 HRS. HOURS <i></i> MIN. <i></i>		
7a. BIRTHPLACE (State or foreign country) <i>Mo.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>HARFORD</i> Md.				
10. CITY OR TOWN OF DEATH <i>HAVERDE GRACE</i>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>HARFORD Memorial Hosp.</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md.</i>			13b. COUNTY <i>HARFORD</i>		13c. CITY OR TOWN <i>HAVERDE GRACE</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>202 N. Washington St.</i>	
14. FATHER'S NAME First <i>GEORGE</i> Middle <i>A.</i> Last <i>BURNS</i>			15. MOTHER'S MAIDEN NAME First <i>ANNA LOUISE</i> Middle <i>PRIEST</i> Last <i></i>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>NO</i> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. <i>220-36-2561</i>		17. INFORMANT Address <i>LOUISE B. WALLER, HAVERDE GRACE, MD. 21078</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <i>1519</i> IMMEDIATE CAUSE (a) <i>Ca. of stomach</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i></i> DUE TO, OR AS A CONSEQUENCE OF (c) <i></i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <i>151X</i>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>3-6 months</i>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <i>A.S.C.U.D. + Malnutrition</i>										
19a. DATE OF OPERATION <i></i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i></i>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i></i>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. <i>19</i> Month <i></i> Day <i></i> Year <i></i> P.M. <i></i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <i></i>						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <i></i> of work <i></i>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <i></i>		21f. LOCATION Street or R.F.D. No. <i></i> City or Town <i></i> County <i></i> State <i></i>						
22a. I certify that (I) (this hospital) attended the deceased from <i>5/18</i> , 19 <i>68</i> , to <i>6/6</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>6/6</i> , 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <i>Edward C. Loo</i>		22c. DATE SIGNED <i>6/6/68</i>		22d. PHYSICIAN'S NAME (Type) <i>Edward C. Loo, M.D.</i>		22e. ADDRESS <i>HAVERDE GRACE, Md.</i>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		23b. DATE <i>JUNE 9 1968</i>		23c. NAME OF CEMETERY OR CREMATORY <i>ANGEL HILL CEM.</i>		23d. LOCATION (City or Town) (County) (State) <i>HAVERDE GRACE HARFORD MD.</i>				
24. FUNERAL DIRECTOR <i>R. Madison Mitchell</i>		25a. REC'D BY REGISTRAR <i></i>		25b. REGISTRAR'S SIGNATURE <i></i>		DATE <i>JUN 10 1968</i>				

8303

CENTRAL OF DEATH

8303

JUN 15 1958

FOR STATE
HEALTH/DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												08504
Item #2a, Film 401 6/2 MEDICAL EXAMINER'S CERTIFICATE OF DEATH												08499
1. DECEASED-NAME (Type or Print) <u>LISA ANN CRESWELL</u>						2a. DATE KNOWN OF DEATH ESTIMATED <input type="checkbox"/> <u>Unknown</u>			2b. HOUR M			
3. SEX <u>F</u>	4. RACE <u>W</u>	5. DATE OF BIRTH <u>3-18-68</u>	6. AGE (In years last birthday) YRS. <u>3</u>	IF UNDER 1 YEAR MONTHS <u>3</u> DAYS	IF UNDER 24 HRS HOURS <u>3</u> MIN.	2c. DATE PRONOUNCED DEAD Month <u>JUNE</u> Day <u>15</u> Year <u>68</u>			2d. HOUR <u>9 AM</u>			
7a. BIRTHPLACE (State or foreign country) <u>MD-BAL</u>		7b. CITIZEN OF WHAT COUNTRY? <u>USA</u>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <u>HARFORD</u> Md.						
10. CITY OR TOWN OF DEATH <u>Joppa</u>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>1618 DUNBAR DR</u>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <u>MD</u>			13b. COUNTY <u>HARFORD</u>		13c. CITY OR TOWN <u>JOPPA</u>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <u>1618 DUNBAR DR</u>			
14. FATHER'S NAME First Middle Last <u>GEORGE B. CRESWELL</u>				15. MOTHER'S MAIDEN NAME First Middle Last <u>AUDRY JANNEY</u>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>			16b. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>GEO. CRESWELL</u>			ADDRESS <u>ABOVE</u>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>SPH</u> <u>795X</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o) <u>7955</u>												
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. <u>19</u>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion												
ACTUAL SIGNATURE <u>Gerald E Palmer</u> M.D.						CHIEF MEDICAL EXAMINER <input type="checkbox"/> B-1 A.C. M. Md.						
EXAMINER'S NAME (Type) <u>Gerald E Palmer M.D.</u>						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> 22b. DATE SIGNED <u>6-15-68</u>						
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>						ADDRESS (Street, city, town, or county)						
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>6/17/68</u>		23c. NAME OF CEMETERY OR CREMATORY <u>BELAIR CEM.</u>			23d. LOCATION (City or Town) (County) (State) <u>HARFORD MD</u>					
24. FUNERAL DIRECTOR <u>J.E. CONNELLY SONS</u>						ADDRESS <u>300 MACE</u>		25a. REC'D BY REGISTRAR <u>JUN 20 1968</u>		25b. REGISTRAR'S SIGNATURE <u>Charles J. J...</u>		

85-04974

20230

CIVIL SERVICE

U.S. DEPARTMENT OF JUSTICE

WASHINGTON, D.C.

OFFICE OF THE ATTORNEY GENERAL

DIVISION OF INVESTIGATION

UNIT OF RECORDS AND COMMUNICATIONS

SECTION OF INVESTIGATION

SUBSECTION OF INVESTIGATION

BRANCH OF INVESTIGATION

DIVISION OF INVESTIGATION

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DIVISION OF INVESTIGATION

UNIT OF RECORDS AND COMMUNICATIONS

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 415
30M REV 1/68

08500				DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				08505				
Item 5,6, Film 401 6/14/68km				CERTIFICATE OF DEATH								
1. DECEASED-NAME (Type or print) Ernest Tyson Cullen			First Middle Last			2a. DATE OF DEATH Month 6 Day 2 Year 1968			2b. HOUR M M			
3. SEX Male		4. RACE White		5. DATE OF BIRTH 7--28--1886			6. AGE (In years last birthday) 78 YRS.		IF UNDER 1 YEAR MONTHS 0 DAYS 0		IF UNDER 24 HRS. HOURS 0 MIN 0	
7a. BIRTHPLACE (State or foreign country) Penna.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Harford Co. Md.					
10. CITY OR TOWN OF DEATH Havre de Grace			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Harford Memorial Hosp.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Farming			12b. KIND OF BUSINESS OR INDUSTRY Own Farm			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.			13b. COUNTY Cecil		13c. CITY OR TOWN Port Deposit		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER R.F.D.			
14. FATHER'S NAME John Cullen			First Middle Last			15. MOTHER'S MAIDEN NAME Anna Tyson			First Middle Last			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No			16b. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Mildred Cullen Port Deposit Md.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident 4129 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) A.S.C.U.D. DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4221												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from May , 19 62 , to June , 19 62 , that (I) (we) last saw the deceased alive on 6-3-62 , 19 62 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE Ernest W. Seiter						DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED June 3, 1962			
22d. PHYSICIAN'S NAME (Type) Ernest W. Seiter						22e. ADDRESS Rising Sun Md.						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE 6-6-1968		23c. NAME OF CEMETERY OR CREMATORY West Nottingham Cem.			23d. LOCATION (City or Town) (County) (State) Colora Cecil Md.				
24. FUNERAL DIRECTOR Ernest W. Cullen						ADDRESS Rising Sun, Md.			25a. REC'D BY REGISTRAR DATE JUN 6 1968			
									25b. REGISTRAR'S SIGNATURE Charles Judge			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
08501 CERTIFICATE OF DEATH 08506

1. PLACE OF DEATH a. COUNTY Harford MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Fallston				c. LENGTH OF STAY IN 1b 17 yrs.			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Friendship Road				d. STREET ADDRESS Friendship Road			
3. NAME OF DECEASED (Type or print) James Peter Farmer				4. DATE OF DEATH June 16, 1968			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4/25/1873	
9. AGE (In years last birthday) 95 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Gen. farming		9. AGE (In years last birthday) Months Days Hours Min. 95 yrs.	
11. BIRTHPLACE (County & State, or foreign country) Ash Co. N.C.				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Hilton Farmer				14. MOTHER'S MAIDEN NAME Martiscia Roten			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 219-36-1267			
17. INFORMANT Mrs. Carrie May Farmer				Address RD #2 Box 28 Fallston, Md 21047			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 4109 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chr. Arteriosclerotic Cardiovascular Disease DUE TO (c) 15 y							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 4201							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from May, 19 27 to June 16, 19 68 , that (I) (we) last saw the deceased alive on June 16 1968 , and that death occurred at 8:15 p.m. from the causes and on the date stated above.							
22a. SIGNATURE Willard P. Hudson				22b. DATE SIGNED 6/17/68			
22c. PHYSICIAN'S NAME (Type) Willard P. Hudson, M.D.				22d. ADDRESS Forest Hill, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6/19/1968		23c. NAME OF CEMETERY OR CREMATORY Centre		23d. LOCATION (City, town or county) (State) Forest Hill, Harford, Md	
24. FUNERAL DIRECTOR Charles E. Kurtz				25a. REC'D BY REGISTRAR JUN 18 1968			
25b. REGISTRAR'S SIGNATURE Charles E. Kurtz				25b. REGISTRAR'S SIGNATURE Charles E. Kurtz			

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Washington, D.C.
May 10, 1968

Dear Mr. [Name]

I am writing to you regarding the [Topic].
The [Topic] is a matter of [Topic].
I am sure that you will find this information [Topic].

I am sure that you will find this information [Topic].
I am sure that you will find this information [Topic].

I am sure that you will find this information [Topic].
I am sure that you will find this information [Topic].

I am sure that you will find this information [Topic].
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I am sure that you will find this information [Topic].
I am sure that you will find this information [Topic].

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR 400
30M REV. 1-68

08502				DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				08507											
1. DECEASED-NAME (Type or print)				First		Middle		Last		20. DATE OF DEATH			2b. HOUR						
Hatcher				D		Gordon		6			Month 5 Day 68		11A M						
3. SEX		4. RACE		5. DATE OF BIRTH				6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.							
M		W		12-31-1883				84 YRS.		MONTHS DAYS		HOURS MIN.							
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH						Md.							
Virginia		USA		USA		Harford													
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)				12b. KIND OF BUSINESS OR INDUSTRY									
Havre de Grace		Citizens Nursing Home				crane operator				Retired									
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER											
Md.		Harford		Havre de Grace		YES <input type="checkbox"/> NO <input type="checkbox"/>		420 S. Washington, St.											
14. FATHER'S NAME				First		Middle		Last		15. MOTHER'S MAIDEN NAME				First Middle Last					
?										?									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service)				16b. SOCIAL SECURITY NO.		17. INFORMANT								Address					
Yes, no, or unknown				220-22-0368		Lowell Gordon								Cape St. Clair, Annapolis, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART I. DEATH WAS CAUSED BY:																			
IMMEDIATE CAUSE (a) 4409 CARDIAC FAILURE																			
DUE TO, OR AS A CONSEQUENCE OF (b) Anteriosclerosis																			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.																			
DUE TO, OR AS A CONSEQUENCE OF (c)																			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																			
4500																			
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)				21f. LOCATION Street or R.F.D. No. City or Town County State											
22a. I certify that (I) (this hospital) attended the deceased from 1956, 19, to 6-5, 1968, that (I) (we) last saw the deceased alive on 6/1, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																			
22b. SIGNATURE												DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED			
6-5/68																6-5/68			
22d. PHYSICIAN'S NAME (Type)												22e. ADDRESS							
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City or Town) (County) (State)									
6/8/68				Ansel Hill		Harford County, Md.													
24. FUNERAL DIRECTOR												25a. REC'D BY REGISTRAR		JUN 11 1968		REGISTRAR'S SIGNATURE			
Cunnington & Son												Havre de Grace, Md.							

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

08503

08508

1. DECEASED-NAME (Type or print) <i>Letitia Green</i>			First <i>Ada</i> Middle <i>Letitia</i> Last <i>Green</i>			2a. DATE OF DEATH Month <i>6</i> Day <i>11</i> Year <i>68</i>			2b. HOUR <i>6:45</i> P M		
3. SEX <i>Female</i>			4. RACE <i>White</i>			5. DATE OF BIRTH <i>02-20-77</i>			6. AGE (In years last birthday) <i>91</i> YRS.		
7a. BIRTHPLACE (State or foreign country) <i>Virginia</i>			7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <i>HARFORD</i> Md.		
10. CITY OR TOWN OF DEATH <i>HAVRE DE GRACE, MD</i>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Green's Nursing Home</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Housewife</i>			12b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Maryland</i>			13b. COUNTY <i>Harford</i>			13c. CITY OR TOWN <i>Bel Air</i>			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
13e. STREET AND NUMBER <i>1008 Leeswood Road</i>			14. FATHER'S NAME First <i>John</i> Middle <i>D</i> Last <i>Hoind</i>			15. MOTHER'S MAIDEN NAME First <i>Elizabeth</i> Middle <i>Esther</i> Last <i>Scott</i>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>No</i> (If yes give war or dates of service) <i>----</i>		
16b. SOCIAL SECURITY NO. <i>218-52-2743</i>			17. INFORMANT <i>J. Garland Green</i>			1008 Address <i>Leeswood Rd.</i>			17. INFORMANT <i>Bel Air, Md. 21014</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Hypostatic pneumonia</i> <i>4129</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Q. S. C. V. D.</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>-----</i>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>4 days</i>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <i>4221</i>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <i>1-10</i> , 19 <i>68</i> , to <i>6-11</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>6-10</i> 19 <i>68</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>W. K. Brendle</i>						22c. DATE SIGNED <i>6/11/68</i>					
22d. PHYSICIAN'S NAME (Type) <i>William K. Brendle</i>						22e. ADDRESS <i>Havre de Grace, Maryland</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>			23b. DATE <i>6/14/1968</i>			23c. NAME OF CEMETERY OR CREMATORY <i>Centre</i>			23d. LOCATION (City or Town) (County) (State) <i>Forest Hill, Harford, Md.</i>		
24. FUNERAL DIRECTOR <i>Charles E. Kurtz</i>						25a. REC'D BY REGISTRAR <i>Charles E. Kurtz</i>			25b. REGISTRAR'S SIGNATURE <i>Charles E. Kurtz</i>		
25c. ADDRESS <i>Kurtz Funeral Home, Garrettville Md</i>						DATE <i>JUN 13 1968</i>					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 15-54-1
30M REV 1/78

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print) <i>Catherine Mary Hoffman</i>			First Middle Last			2a. DATE OF DEATH Month <i>June</i> Day <i>6</i> Year <i>68</i>		2b. HOUR <i>7:10</i> M		
3. SEX <i>FEMALE</i>		4. RACE <i>WHITE</i>		5. DATE OF BIRTH <i>September 24, 1904</i>		6. AGE (In years lost birthday) <i>63</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) <i>MD</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Harford</i> Md.				
10. CITY OR TOWN OF DEATH <i>Harford</i>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Harford Memorial Hosp</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Homemaker</i>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>MD</i>			13b. COUNTY <i>Harford</i>		13c. CITY OR TOWN <i>Bel Air</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>211 Fulton Ave</i>	
14. FATHER'S NAME First Middle Last <i>William M. Griffith</i>			15. MOTHER'S MAIDEN NAME First Middle Last <i>Clara L. Jones</i>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <i>No</i>			16b. SOCIAL SECURITY NO. <i>213-18-0610</i>		17. INFORMANT (Husband) <i>838-5627</i> <i>Mr. George K. Hoffman</i>		Address <i>211 Fulton Ave, Bel Air, Maryland 21014</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Cerebrovascular Accident</i> <i>436.0</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) <i>Hypertension - General Arterio</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Atherosclerosis and Diabetes</i>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>30 min</i>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>331X</i>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <i>6-6</i> , 19 <i>68</i> , to <i>6/6</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>6-6</i> , 19 <i>68</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <i>Dudley Phillips MD</i>					DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE/SIGNED <i>6/6/68</i>			
22d. PHYSICIAN'S NAME (Type) <i>Dudley Phillips MD</i>					22e. ADDRESS <i>DARLINGTON MD 21034</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>JUNE 8, 1968</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Bel Air Memorial Gardens</i>		23d. LOCATION (City or Town) (County) (State) <i>Bel Air Harford Co. Maryland 21014</i>				
24. FUNERAL DIRECTOR <i>Joseph William Foster</i> ADDRESS <i>W. Broadway & Williams St. Bel Air, Maryland 21014</i>					25a. REC'D BY REGISTRAR DATE <i>JUN 10 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

1. The first part of the report is a general description of the project and its objectives. It includes a brief history of the project and a statement of the problem to be solved. The second part of the report is a detailed description of the methods used in the study. This includes a description of the experimental design, the data collection procedures, and the statistical methods used to analyze the data. The third part of the report is a discussion of the results of the study. This includes a description of the findings, a comparison of the results with previous studies, and a discussion of the implications of the findings. The fourth part of the report is a conclusion and a list of references.

2. The first part of the report is a general description of the project and its objectives. It includes a brief history of the project and a statement of the problem to be solved. The second part of the report is a detailed description of the methods used in the study. This includes a description of the experimental design, the data collection procedures, and the statistical methods used to analyze the data. The third part of the report is a discussion of the results of the study. This includes a description of the findings, a comparison of the results with previous studies, and a discussion of the implications of the findings. The fourth part of the report is a conclusion and a list of references.

3. The first part of the report is a general description of the project and its objectives. It includes a brief history of the project and a statement of the problem to be solved. The second part of the report is a detailed description of the methods used in the study. This includes a description of the experimental design, the data collection procedures, and the statistical methods used to analyze the data. The third part of the report is a discussion of the results of the study. This includes a description of the findings, a comparison of the results with previous studies, and a discussion of the implications of the findings. The fourth part of the report is a conclusion and a list of references.

4. The first part of the report is a general description of the project and its objectives. It includes a brief history of the project and a statement of the problem to be solved. The second part of the report is a detailed description of the methods used in the study. This includes a description of the experimental design, the data collection procedures, and the statistical methods used to analyze the data. The third part of the report is a discussion of the results of the study. This includes a description of the findings, a comparison of the results with previous studies, and a discussion of the implications of the findings. The fourth part of the report is a conclusion and a list of references.

5. The first part of the report is a general description of the project and its objectives. It includes a brief history of the project and a statement of the problem to be solved. The second part of the report is a detailed description of the methods used in the study. This includes a description of the experimental design, the data collection procedures, and the statistical methods used to analyze the data. The third part of the report is a discussion of the results of the study. This includes a description of the findings, a comparison of the results with previous studies, and a discussion of the implications of the findings. The fourth part of the report is a conclusion and a list of references.

FOR STATE
HEALTH DEPT.

any delay is
24 hours after death
18. Give Pages 1, 2, and 3 to
the funeral director, Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMA-1000
5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages read 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201																	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH																	
1. DECEASED-NAME (Type or Print)			First Raymond			Middle C.			Last Ingool			2a. DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> 6 28 19 68			2b. HOUR M		
3. SEX Male		4. RACE White		5. DATE OF BIRTH April 30, 1943		6. AGE (In years last birthday) 25 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		2c. DATE PRONOUNCED DEAD Month 6 Day 28 Year 19 68			2d. HOUR 12:30 a.m.				
7a. BIRTHPLACE (State or foreign country) Md.				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. COUNTY OF DEATH Coomes Harford Md.					
10. CITY OR TOWN OF DEATH Bel Air				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Hartford Memorial				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Partsman				12b. KIND OF BUSINESS OR INDUSTRY auto					
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE Maryland				13b. COUNTY Coomes				13c. CITY OR TOWN Bel Air		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER Thomas Run Road					
14. FATHER'S NAME Zillery Cleo Ingool				15. MOTHER'S MAIDEN NAME Eula Bernice Crabb				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no				16b. SOCIAL SECURITY NO. 218-38-3611					
17. INFORMANT Zillery C. Ingool, Box 45, Street, Md.				17. ADDRESS													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Stab wound of chest (homicide) 966X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO, OR AS A CONSEQUENCE OF (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 981X																	
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year 11:30 a.m. 6 27 19 68				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) Stabbed During Altercation									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) home				21f. LOCATION Street or R.F.D. No. City or Town County State Thomas Run Road Bel Air Coomes Harford Md.									
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>																	
ACTUAL SIGNATURE <i>Ronald N. Kornblum</i>				M.D. Ronald N. Kornblum, M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ADDRESS (Street, city, town, or county)									
22b. DATE SIGNED 6-28-68																	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE July 1, 1968				23c. NAME OF CEMETERY OR CREMATORY Bel Air Memorial Gardens									
23d. LOCATION (City or Town) (County) (State) Bel Air Harford Md				24. FUNERAL DIRECTOR Howard K. McComas & Son, Abingdon, Md.				25a. REC'D BY REGISTRAR JUL - 1 1968									
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>																	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

08506		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		08511	
Item #5, Film G402 7/5/68 km		CERTIFICATE OF DEATH			
1. DECEASED-NAME (Type or print) First Middle Last <i>Lydia Ann Jackson</i>			2a. DATE OF DEATH Month Day Year <i>6 16 68</i>		2b. HOUR <i>8:30 P M</i>
3. SEX <i>Female</i>	4. RACE <i>White</i>	5. DATE OF BIRTH <i>May 6, 1895</i>		6. AGE (In years last birthday) YRS. MONTHS DAYS <i>72</i>	
7a. BIRTHPLACE (State or foreign country) <i>Md</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		9. COUNTY OF DEATH <i>HARFORD.</i> Md.	
10. CITY OR TOWN OF DEATH <i>Harre-de-Grace</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Harford Memorial Hospital</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Housewife</i>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md</i>		13b. COUNTY <i>Cecil Perryville</i>		13c. STREET AND NUMBER <i>Cecil Ave</i>	
14. FATHER'S NAME First Middle Last <i>John James Salik</i>			15. MOTHER'S MAIDEN NAME First Middle Last <i>Catherine Renner</i>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no (If yes give war or dates of service) <i>NO</i>		16b. SOCIAL SECURITY NO. <i>Unknown</i>		17. INFORMANT Address <i>Hospital Records, Harre de Grace Md</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Abdominal Carcinomatosis</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Perif Carcinoma of Cecum</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>1 yr.</i> 1530 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2 mos</i>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 1530					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <i>May</i> , 19 <i>67</i> , to <i>June 16</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>June 16</i> , 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>W H Sadowsky MD</i>				22c. DATE SIGNED <i>6/16/68</i>	
22d. PHYSICIAN'S NAME (Type) <i>W H SADOWSKY, MD</i>				22e. ADDRESS <i>504 LEWIS ST. HARRE DE GRACE</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <i>6/19/68</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Harford Memorial Cemetery</i>	
24. FUNERAL DIRECTOR <i>W C Peterson</i>		25a. REC'D BY REGISTRAR <i>Charles Judge</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A 15 10
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print) DORA			First N.M.V. Middle Jenkins Last			2a. DATE OF DEATH Month June Day 9 Year 68		2b. HOUR 11:58 M		
3. SEX Female		4. RACE Negro		5. DATE OF BIRTH May 10, 1910		6. AGE (In years lost birthday) 58 YRS.		IF UNDER 1 YEAR MONTHS 1 DAYS 1 HOURS 1 MIN.		
7a. BIRTHPLACE (State or foreign country) Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Harford Md.				
10. CITY OR TOWN OF DEATH Lane de Grace			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Harford Memorial Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Housewife		
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE Md.			13b. COUNTY Harford		13c. CITY OR TOWN Harford		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 553 Alliance St.	
14. FATHER'S NAME First Mose Middle Minor Last			15. MOTHER'S MAIDEN NAME First Susie Middle Pitchough Last							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown no (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT Mr. James Jenkins - Harde Grace, Md. Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 174X Tubercular meningitis DUE TO, OR AS A CONSEQUENCE OF (b) advanced Ca of Rt. Breast - Radiant DUE TO, OR AS A CONSEQUENCE OF (c) chronic pyelitis & Bone metastasis								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days 12 years 10 months		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 170X										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to June 9, 1968 , that (I) (we) last saw the deceased alive on June 9, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Maher Ishrak					DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (Type) Maher Ishrak					22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 6-13-68		23c. NAME OF CEMETERY OR CREMATORY Barkley Cemetery		23d. LOCATION (City or Town) (County) (State) Darlington Harford, Md.				
24. FUNERAL DIRECTOR Stella J. Bullock, Harde Grace, Md.					25a. REC'D BY REGISTRAR DATE JUN 17 1968		25b. REGISTRAR'S SIGNATURE Charles Young			



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A 15 (A)
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH															
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201															
CERTIFICATE OF DEATH															
1. DECEASED-NAME (Type or print)			First		Middle		Last		2c. DATE OF DEATH		2b. HOUR				
Mary			Johnson						Month 6 Day 6 Year 68		9:25A M				
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (In years last birthday)			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN	
Female			Negro			Oct. 24, 1905			62 YRS.			7 12			
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH						
Windsor, N. Car.			USA						Harford Md.						
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY						
Havre de Grace, Md.			Brevin Nursing Home Inc			Raised Foster children			Housewife						
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER			
Maryland			Harford			Havre de Grace						860 Erie Street			
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME												
First Middle Last			First Middle Last												
Vaughn			Harding			Laura (No record)									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, (if give war or dates of service) No			16b. SOCIAL SECURITY NO.			17. INFORMANT			Address						
			216-182-712			Mr. Harry J. Johnson			Havre de Grace, Md.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1951 Melastatic neoplasm of pelvis. DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) 1992															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)									
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State									
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE			22c. DATE SIGNED												
22d. PHYSICIAN'S NAME (Type)			22e. ADDRESS												
Dr. I. Lajos Mezei			601 S. Union Ave., Havre de Grace, Md.												
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)						
Burial			6-10-68			Berkley Cemetery			Baltimore, Harford, Md.						
24. FUNERAL DIRECTOR			ADDRESS			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE						
Otelia J. Bullock, Havre de Grace, Md.			21075			DATE JUN 17 1968			Charles J. Judge						

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15-54
30M REV. 1-48

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
CERTIFICATE OF DEATH												
1. DECEASED-NAME (Type or print) <i>Samantha M.M. Jones</i>						2a. DATE OF DEATH Month <i>6</i> Day <i>13</i> Year <i>68</i>			2b. HOUR <i>3:30</i> M			
3. SEX <i>Female</i>		4. RACE <i>Negro</i>		5. DATE OF BIRTH <i>March 13, 1893</i>			6. AGE (In years last birthday) <i>75</i> YRS.		IF UNDER 1 YEAR MONTHS <i>0</i> DAYS <i>0</i>		IF UNDER 24 HRS. HOURS <i>0</i> MIN. <i>0</i>	
7a. BIRTHPLACE (State or foreign country) <i>Md</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>HARFORD</i> Md.						
10. CITY OR TOWN OF DEATH <i>Harrode-Grace</i>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Harrode Memorial Hospital</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Housewife</i>			12b. KIND OF BUSINESS OR INDUSTRY <i>Housewife</i>			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md</i>			13b. COUNTY <i>Harford</i>			13c. CITY OR TOWN <i>Harrode-Grace</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>5516 Girard St.</i>		
14. FATHER'S NAME First <i>Joseph</i> Middle <i>Bradley</i> Last <i>Stokes</i>				15. MOTHER'S MAIDEN NAME First <i>Mary</i> Middle <i>Stokes</i> Last <i>Stokes</i>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>no</i>				16b. SOCIAL SECURITY NO. <i>-</i>		17. INFORMANT Address <i>Mr. J. Leo Jones, Harrode Grace, Md.</i>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Adams stivis Syndrome / Brain Tumour.</i> 4129 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>A.S.H.D. Repeated dizzy spells.</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>2-3 years.</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 week.</i>												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4200 <i>Bronchopneumonia, around of Lye Cy.</i>												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State								
22a. I certify that (I) (this hospital) attended the deceased from <i>6-7</i> , 19 <i>68</i> , to <i>6-13</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>6-13</i> , 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <i>Maher Ishaq</i>						DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED				
22d. PHYSICIAN'S NAME (Type) <i>MAHER ISHAQ</i>						22e. ADDRESS						
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>6-17-68</i>		23c. NAME OF CEMETERY OR CREMATORY <i>St. James A.M.E. Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Harrode Grace, Harford, Md.</i>						
24. FUNERAL DIRECTOR <i>Otelia J. Bullock, Harrode Grace, Md.</i>						25a. REC'D BY REGISTRAR <i>JUN 19 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>				

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or Print)		First	Middle	Last	2a. DATE KNOWN OF DEATH		Month	Day	Year	2b. HOUR	
THEODORE				MALLOY	MATED <input checked="" type="checkbox"/>		6	18	68	7:22 p.m.	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (In years last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD		
male	negro	9/8/03		64 YRS.	MONTHS	DAYS	HOURS	MIN.	Month	Day	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
		U.S.A.				Harford Md.					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
Haver De Grace			Maryland House Restaurant			Laborer					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER	
Washington, D.C.						Washington		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		411 Illinois Avenue	
14. FATHER'S NAME				First		Middle		Last		15. MOTHER'S MAIDEN NAME	
										First Middle Last	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS					
						Joseph Malloy 4111 Illinois Ave.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease											
4129 DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
(b) DUE TO, OR AS A CONSEQUENCE OF											
(c) DUE TO, OR AS A CONSEQUENCE OF											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
4221											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?			
								XXXX NO XX			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
		HOUR A.M. P.M. 19									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.				City or Town		County State	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE		Werner U. Spitz, M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED			
EXAMINER'S NAME (Type)						ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		6/18/68			
						DEPUTY MEDICAL EXAMINER <input type="checkbox"/>					
						ADDRESS (Street, city, town, or county)					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)	
Burial		6/22/68		Carver Mem. Park		Murkirk, Maryland					
24. FUNERAL DIRECTOR				ADDRESS				25a. REC'D BY REGISTRY		25b. REGISTRAR'S SIGNATURE	
Charles A. Rice 661 W. Barre St.								JUN 20 1968		J. A. J. J.	

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REPORT

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CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove urban papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print) Donald		First L.		Middle McClain		Last McClain		2a. DATE OF DEATH Month June Day 3 Year 68			2b. HOUR 11 PM	
3. SEX male		4. RACE Cauc		5. DATE OF BIRTH JULY 14 1909			6. AGE (In years lost birthday) 58 YRS.			IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN		
7a. BIRTHPLACE (State or foreign country) md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Harford.						
10. CITY OR TOWN OF DEATH Harve De Grace		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) STATE OF MD			12b. KIND OF BUSINESS OR INDUSTRY MAINTENANCE			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE md		13b. COUNTY Harford		13c. CITY OR TOWN Harve De Grace		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER ST. MILITARY RES.				
14. FATHER'S NAME First GARFIELD Middle L. Last McCLAIN		15. MOTHER'S MAIDEN NAME First DELIA Middle HARBAUGH Last										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) NO		16b. SOCIAL SECURITY NO. YES		17. INFORMANT State Military Dir. Harve De Grace Md								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4109 Coronary Thrombosis DUE TO, OR AS A CONSEQUENCE OF (b) Coronary Arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerotic Cardiovascular Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. ? APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 day.												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) 4201												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State								
22a. I certify that (I) (this hospital) attended the deceased from 2/10/60 to 6/1/68 , that (I) (we) last saw the deceased alive on 6/1/68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE Edward C. Loo, M.D.		DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 6/1/68		
22d. PHYSICIAN'S NAME (Type) Edward C. Loo, M.D.		22e. ADDRESS Harve De Grace, Md.										
23a. BURIAL, CREMATION, REMOVAL (Specify) Buried		23b. DATE 5/5/68		23c. NAME OF CEMETERY OR CREMATORY Angel Hill Cemetery		23d. LOCATION (City or Town) (County) (State) Harve De Grace Harford Md						
24. FUNERAL DIRECTOR Pennington + Son, Harve De Grace, Md		ADDRESS		25a. REC'D BY REGISTRAR JUN 6 1968		25b. REGISTRAR'S SIGNATURE Charles Judge						

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

08512

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08517

1. DECEASED-NAME (Type or Print) Joe Leslie McWilliams, Sr.			2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month June Day 12 Year 1968			2b. HOUR M			
3. SEX Male	4. RACE White	5. DATE OF BIRTH Jan. 29, 1921	6. AGE (in years last birthday) 47 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD Month June Day 12 Year 1968			
7a. BIRTHPLACE (State or country) San Antonio, Texas		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Harford County, Md.			
10. CITY OR TOWN OF DEATH Bel Air		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 421 Linwood Avenue			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Service & Sales Engineer- Chemical		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Harford		13c. CITY OR TOWN Bel Air		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 421 Linwood Avenue	
14. FATHER'S NAME First Andrew Middle Gentry Last McWilliams			15. MOTHER'S MAIDEN NAME First Martha Middle Jane Last Morris			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, never unknown) Yes WW#2			
16b. SOCIAL SECURITY NO. 439-01-7121			17. INFORMANT (Name) Mrs. Geraldine B. McWilliams			17. ADDRESS 421 Linwood Ave. Bel Air, Md. 21014			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 4109 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 4201									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE Gerald C. Palmer			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED June 12, 1968			
EXAMINER'S NAME (Type) Gerald C. Palmer, M.D.			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			ADDRESS (Street, city, town, or county) S. Main St., Bel Air, Md. 21014			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE June 15, 1968		23c. NAME OF CEMETERY OR CREMATORY Gracelawn Mem. Park, Inc.		23d. LOCATION (City or Town) (County) (State) New Castle, New Castle Co., Del.			
24. FUNERAL DIRECTOR Joseph William Foster				W. Broadway & Williams Bel Air, Maryland 21014		25a. REC'D BY REGISTRAR JUN 14 1968		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

[illegible]

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Items #11, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08513 08518

1. DECEASED NAME (Type or Print) John Fred Moses										2a. DATE KNOWN OF DEATH <input type="checkbox"/> Month <input type="checkbox"/> Day <input type="checkbox"/> Year <input type="checkbox"/> 19 <input type="checkbox"/> 19 <input type="checkbox"/> 19				2b. HOUR <input type="checkbox"/> M <input type="checkbox"/> AM			
3. SEX M		4. RACE C		5. DATE OF BIRTH Jan 4 1898		6. AGE (in years last birthday) 70 YRS.		IF UNDER 1 YEAR MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/>		IF UNDER 24 HRS HOURS <input type="checkbox"/> MIN <input type="checkbox"/>		2c. DATE PRONOUNCED DEAD Same Day 7 Year 19 68				2d. HOUR 10 M <input type="checkbox"/> AM	
7a. BIRTHPLACE (State or foreign country) Grassow Co VA				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. COUNTY OF DEATH Harris Md.					
10. CITY OR TOWN OF DEATH Bel Air Md				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Residence, Bel Air, Md				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)				12b. KIND OF BUSINESS OR INDUSTRY					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland				13b. COUNTY Harford				13c. CITY OR TOWN Bel Air				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER Baltimore Pike, Route 1			
14. FATHER'S NAME First Louie Reers Middle Reers Last Lew						15. MOTHER'S MAIDEN NAME First Moses Middle Moses Last Moses											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)						16b. SOCIAL SECURITY NO. 225-14-8456						17. INFORMANT ADDRESS Schell Green BOWLS BUNN					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic CV Disease DUE TO, OR AS A CONSEQUENCE OF (b) 4129 DUE TO, OR AS A CONSEQUENCE OF (c) 4221 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)																	
19a. DATE OF OPERATION 4221						19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year 19 HOUR A.M. <input type="checkbox"/> P.M. <input type="checkbox"/>				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No. City or Town County State									
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																	
ACTUAL SIGNATURE Gerald E Palmer M.D.						CHIEF MEDICAL EXAMINER <input type="checkbox"/>						Be/Hir: M					
EXAMINER'S NAME (Type) Gerald E Palmer MD						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>						22b. DATE SIGNED 6-7-68					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial						23b. DATE 6-11-68		23c. NAME OF CEMETERY OR CREMATORY Independence Cemetery				23d. LOCATION (City or Town) (County) (State) Independence					
24. FUNERAL DIRECTOR George W Tittle Bel Air Md						25a. REC'D BY REGISTRAR JUN 13 1968				25b. REGISTRAR'S SIGNATURE Charles Juge							

1. Name of landowner _____

2. Name of tenant _____

3. Name of operator _____

4. Name of owner of machinery _____

5. Name of owner of land _____

6. Name of owner of building _____

7. Name of owner of other property _____

8. Name of owner of other property _____

9. Name of owner of other property _____

10. Name of owner of other property _____

11. Name of owner of other property _____

12. Name of owner of other property _____

13. Name of owner of other property _____

14. Name of owner of other property _____

15. Name of owner of other property _____

16. Name of owner of other property _____

17. Name of owner of other property _____

18. Name of owner of other property _____

19. Name of owner of other property _____

20. Name of owner of other property _____

21. Name of owner of other property _____

22. Name of owner of other property _____

23. Name of owner of other property _____

24. Name of owner of other property _____

25. Name of owner of other property _____

26. Name of owner of other property _____

27. Name of owner of other property _____

28. Name of owner of other property _____

29. Name of owner of other property _____

30. Name of owner of other property _____

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is unnecessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. DECEASED NAME (Type or Print)		First		Middle		Last		2a. DATE KNOWN OF ESTI- DEATH MATED		Month		Day		Year		2b. HOUR																															
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (in years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS		2c. DATE PRONOUNCED DEAD		Month		Day		Year		2d. HOUR																											
MALE		W		1900		67		MONTHS		DAYS		HOURS		MIN.		JUNE		5		1968																											
7a. BIRTHPLACE (State or foreign country)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. COUNTY OF DEATH																																			
Kentucky				U. S. A.								HARFORD																																			
10. CITY OR TOWN OF DEATH						11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)						12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)						12b. KIND OF BUSINESS OR INDUSTRY																													
BEL AIR						PROSPECT MILL RD #2						Farmer						Farm																													
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE						13b. COUNTY						13c. CITY OR TOWN						13d. INSIDE CITY LIMITS?						13e. STREET AND NUMBER																							
MD						HARFORD						BEL AIR						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						RTE 2 Box 365																							
14. FATHER'S NAME				First				Middle				Last				15. MOTHER'S MAIDEN NAME				First				Middle				Last																			
Burg				Muller				(D)				Kate				James				(D)																											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16b. SOCIAL SECURITY NO.				17. INFORMANT																ADDRESS																							
No				308-32-1346				Mary Muller, R.D. 2, Bel Air, Maryland																																							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE CONGESTIVE HEART FAILURE</u> 4270 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.																		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 4341																																															
19a. DATE OF OPERATION												19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?												20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																							
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH								21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19								21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																															
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>								21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)								21f. LOCATION Street or R.F.D. No. City or Town County State																															
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																																															
ACTUAL SIGNATURE <u>Philip W. Heuman</u>												CHIEF MEDICAL EXAMINER <input type="checkbox"/>												22b. DATE SIGNED																							
EXAMINER'S NAME (Type) <u>PHILIP W. HEUMAN, M.D.</u>												ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>												JUNE 5, 1968																							
												DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>												ADDRESS (Street, city, town, or county)																							
23a. BURIAL, CREMATION, REMOVAL (Specify)												23b. DATE						23c. NAME OF CEMETERY OR CREMATORY												23d. LOCATION (City or Town) (County) (State)																	
Burial												8 June 1968						Bel Air Memorial Gardens												Bel Air, (Harford) Maryland																	
24. FUNERAL DIRECTOR												Tarring Funeral Home												25a. REC'D BY REGISTRAR												25b. REGISTRAR'S SIGNATURE											
Wilston Macomber Jr.												Aberdeen, Md. 21001												JUN 7 1968																							

RECEIVED BY THE DIRECTOR OF THE BUREAU OF THE ARMY

RECEIVED

TO

X

X

DATE

DATE



1000

1000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) Gaetano		First	Middle	Last	2a. DATE OF DEATH Month 6 Day 29 Year 68			2b. HOUR 6 P M	
3. SEX Male		4. RACE White		5. DATE OF BIRTH May 12, 1903		6. AGE (In years last birthday) 65 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Italy		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Harford Md.			
10. CITY OR TOWN OF DEATH Harre-de-Grace		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Harford Memorial Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Watchman		12b. KIND OF BUSINESS OR INDUSTRY None			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY Cecil		13c. CITY OR TOWN Berryville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER Jasquehorne Ave	
14. FATHER'S NAME First Nicola Middle Notarcola Last MARY		15. MOTHER'S MAIDEN NAME First Maria Middle BRAGALO Last BRAGALO							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO. Unknown		17. INFORMANT Mrs. Yola R. Notarcola, Berryville		Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) embolism of lung 571.9 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 yrs	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 5810									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 6/29/68 , to 6/29/68 , that (I) (we) lost the deceased on 6/29/68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE John D. Yane				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 6/29/68			
22d. PHYSICIAN'S NAME (Type) John D. Yane				22e. ADDRESS Harre-de-Grace Md					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE July 3/1968		23c. NAME OF CEMETERY OR CREMATORY Mt. Zion Cemetery		23d. LOCATION (City or Town) (County) (State) Harre-de-Grace Harford Md			
24. FUNERAL DIRECTOR Lee A. Patterson				ADDRESS San Annyville Md		25a. REC'D BY REGISTRAR MDL - 5 1968		25b. REGISTRAR'S SIGNATURE John Charles Judge	

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form MB-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
08516 Item 2a, File No. 01 6/1 MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or Print) First Middle Last William D. OELMANN						2a. DATE KNOWN OF DEATH MATED <input type="checkbox"/> Month Day Year 19 <input type="checkbox"/> Unknown 19			2b. HOUR M		
3. SEX M		4. RACE W		5. DATE OF BIRTH 11-15-90		6. AGE (In years last birthday) 77 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Md.				7b. CITIZEN OF WHAT COUNTRY? U.S.				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Harford	
10. CITY OR TOWN OF DEATH Harford				11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) Harford Mem. Hosp.				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Cabinet Maker-Stieff Piano Co			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md				13b. COUNTY Harford				13c. CITY OR TOWN Harford		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER 400 Market St				14. FATHER'S NAME First Middle Last Albert Oelmann				15. MOTHER'S MAIDEN NAME First Middle Last Elizabeth Stranz			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes				16b. SOCIAL SECURITY NO. 215-48-8076				17. INFORMANT Creamer		ADDRESS 2930 E. Fayette	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic C V Disease 4129 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 4221											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Gerald P. Palmer M.D.						CHIEF MEDICAL EXAMINER <input type="checkbox"/> Be/Air, M.					
EXAMINER'S NAME (Type) Gerald P. Palmer						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> 22b. DATE SIGNED 6-11-68					
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>						ADDRESS (Street, city, town, or county)					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE 6/14/68		23c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery				23d. LOCATION (City or Town) (County) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR Schimunek Funeral Home, Inc. 3331 Brehms Lane						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE Charles Judge			
DATE JUN 13 1968											

Wm. D. Evans

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH																	
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201																	
CERTIFICATE OF DEATH																	
1. DECEASED-NAME (Type or print) ELMER			First BOYD			Middle PARDEW			Last			2a. DATE OF DEATH Month June Day 8 Year 1968			2b. HOUR 20 P.M.		
3. SEX MALE			4. RACE W			5. DATE OF BIRTH March 24, 1912			6. AGE (In years lost birthday) 55 YRS.			IF UNDER 1 YEAR MONTHS 0 DAYS 0			IF UNDER 24 HRS. HOURS 0 MIN. 0		
7a. BIRTHPLACE (State or foreign country) N.C.			7b. CITIZEN OF WHAT COUNTRY? U.S.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH HARFORD Md.								
10. CITY OR TOWN OF DEATH HAVRE DE GRACE			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) HARFORD MEMORIAL			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Mechanic			12b. KIND OF BUSINESS OR INDUSTRY Auto								
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD			13b. COUNTY HARFORD			13c. CITY OR TOWN Darlington			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET AND NUMBER none					
14. FATHER'S NAME First Albert Middle Avery Last PARDEW			15. MOTHER'S MAIDEN NAME First Sarah Middle Ann Last Cheek														
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, (na, or unknown) no (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. 216-18-6740			17. INFORMANT Ernett Pardew, Darlington, Md.											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral Bronchopneumonia, 5329 DUE TO, OR AS A CONSEQUENCE OF (b) Serous pneumonia, appendiceal abscess drained DUE TO, OR AS A CONSEQUENCE OF (c) chronic duodenal ulcer, transition APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days 2 weeks Several months																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 5410																	
19a. DATE OF OPERATION 5/11/68			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Drainage of appendiceal abscess			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. 19 Month May Day 25 Year 1968			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. Havre de Grace, Maryland			City or Town Darlington			County HARFORD State MD					
22a. I certify that (I) (this hospital) attended the deceased from May 25, 1968 , to June 8, 1968 , that (I) (we) last saw the deceased alive on June 8, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE M. O'Malley			22c. DATE SIGNED June 8, 1968			22d. PHYSICIAN'S NAME (Type) Thomas Namvary, M.D.			22e. ADDRESS Havre de Grace, Maryland								
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE June 11, 1968			23c. NAME OF CEMETERY OR CREMATORY Darlington Cemetery			23d. LOCATION (City or Town) (County) (State) Darlington Harford Md								
24. FUNERAL DIRECTOR Howard K. McComas & Son, Abingdon, Md			25a. REC'D BY REGISTRAR Charles Judge			25b. REGISTRAR'S SIGNATURE Charles Judge			DATE JUN 11 1968								

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) John WARREN PARIS Sr.			2a. DATE OF DEATH Month June Day 28 Year 1968			2b. HOUR 12:15 AM	
3. SEX male		4. RACE white		5. DATE OF BIRTH MAY 15, 1886		6. AGE (In years last birthday) 82 YRS.	
7a. BIRTHPLACE (State or foreign country) PENNA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH HARFORD Md.	
10. CITY OR TOWN OF DEATH HAVRE DE GRACE		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) HARFORD Memorial Hosp.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY CECIL		13c. CITY OR TOWN ELKTON		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER 19 KENT RD		13f. 253 Hattingsworth Manor					
14. FATHER'S NAME First FRANK Middle M. Last PARIS			15. MOTHER'S MAIDEN NAME First ANNA Middle DOUGLAS Last				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. —		17. INFORMANT BENJAMIN H. PARIS Address ELKTON, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Post operative status re leg. amputation 2509 DUE TO, OR AS A CONSEQUENCE OF (b) for Diabetes mellitus + gangrene associated DUE TO, OR AS A CONSEQUENCE OF (c) with acute aneurysm + thrombotic occlusion Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) 260X Pneumonia							
19a. DATE OF OPERATION 6/19/68		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Gangrene left leg		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <input type="checkbox"/> (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. — Minute — Day 19 P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 6-17 , 1968, to 6-28 , 1968, that (I) (we) last saw the deceased alive on 6-28 , 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE R. J. CARPENTER MD				22c. DATE SIGNED 6/28/68		22d. PHYSICIAN'S NAME (Type) R. J. CARPENTER	
22e. ADDRESS HAVRE DE GRACE, Md							
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 6-30-68		23c. NAME OF CEMETERY OR CREMATORY ELKTON CEMETERY		23d. LOCATION (City or Town) (County) (State) ELKTON CECIL Md.	
24. FUNERAL DIRECTOR W. H. PIPPIN FUNERAL HOME, Elkton, Md				25a. REC'D BY REGISTRAR JUL - 1 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	

Department of Health

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A (4-64)
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print) First Middle Last Arthur ----- Patrick			2a. DATE OF DEATH Month Day Year June 19, 1968			2b. HOUR 4P. M			
3. SEX Male		4. RACE White		5. DATE OF BIRTH April 17, 1893		6. AGE (In years lost birthday) 75 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN IF UNDER 24 HRS.	
7a. BIRTHPLACE (State or foreign country) Russell Co., Va.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Harford Co., Md.			
10. CITY OR TOWN OF DEATH Bel Air (Rural)		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Helton Ave. (R.D. #2)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Section Hand		12b. KIND OF BUSINESS OR INDUSTRY Rail Road			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Harford		13c. CITY OR TOWN Bel Air		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER Helton Ave.	
14. FATHER'S NAME First Middle Last James Robert Patrick				15. MOTHER'S MAIDEN NAME First Middle Last Sallie Hess					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No		16b. SOCIAL SECURITY NO. 723-12-9215		17. INFORMANT (Daughter) 838-3734		Address R.D. #2, Box #335-2 Bel Air, Md. 21014			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4129 IMMEDIATE CAUSE (a) Congestive Heart Failure DUE TO, OR AS A CONSEQUENCE OF (b) Chronic Arterio-Sclerotic Cardio-Vascular Disease DUE TO, OR AS A CONSEQUENCE OF (c) Diabetes Mellitus APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 30 min. 10 yr.									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) 4221 Diabetes Mellitus									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from July , 19 59 , to June 19, 1968 , that (I) (we) lost saw the deceased alive on May 28, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Willard P. Hudson DEGREE 22d. PHYSICIAN'S NAME (Type) Willard P. Hudson, M.D.					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22e. ADDRESS Forest Hill, Harford Co., Maryland			22c. DATE SIGNED June 19, 1968	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE June 22, 1968		23c. NAME OF CEMETERY OR CREMATORY Bel Air Memorial Gardens		23d. LOCATION (City or Town) (County) (State) Bel Air, Harford Co., Md. 21014			
24. FUNERAL DIRECTOR Joseph William Foster				25a. REC'D BY REGISTRAR DATE JUN 21 1968		25b. REGISTRAR'S SIGNATURE Charles Jones			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15-41
30M REV. 1/68

08520		MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				08525	
CERTIFICATE OF DEATH							
1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month Day Year		2b. HOUR
WILLIAM			MARSHALL	Presberry, Jr.	JUNE 23 1968		1:50 PM
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
MALE	Colored	November 8, 1906		61 YRS.			
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md.	
MD	U.S.A.			HARTFORD			
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
HARTFORD	HARTFORD MEMORIAL		Recovering Clerk		Expert Grand		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER			
MD	HARTFORD	DARLINGTON		Box 109 RD #2			
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First Middle Last
HENRY		JAMES	Presberry	SUSAN ANN	WASHINGTON		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address	
no		216-03-2416		Mrs. Rosa Lee Presberry, Darlington, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4109 DUE TO, OR AS A CONSEQUENCE OF (b) Myocardial infarct acute (c) cong. h. failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4201							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from June 23, 1968, to June 23, 1968, that (I) (we) last saw the deceased alive on June 23, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE				DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)	
Burial		6-26-68		Berkley Cemetery		Darlington, Darford, Md.	
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
James E. Buckner		Hartford, Md.		DATE JUN 26 1968		Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 48 hours after death.

MDARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

08521

08526

1. DECEASED-NAME (Type or print) <i>Infant</i>		First		Middle		Last		2a. DATE OF DEATH Month <i>JUNE</i> Day <i>12</i> Year <i>68</i>		2b. HOUR <i>2:00</i> P.M.			
3. SEX <i>MALE</i>		4. RACE <i>White</i>		5. DATE OF BIRTH <i>JUNE 12, 1968</i>		6. AGE (In years last birthday) YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (State or foreign country) <i>MS.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>US</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>HARFORD</i> Md.							
10. CITY OR TOWN OF DEATH <i>Harford</i>				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Harford Memorial Hosp.</i>				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)				12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>MD.</i>				13b. COUNTY <i>Harford</i>		13c. CITY OR TOWN <i>Edgewood</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER			
14. FATHER'S NAME First Middle Last <i>Homer Clayton Proctor</i>				15. MOTHER'S MAIDEN NAME First Middle Last <i>Winnie Lucille Spahn</i>									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <i>no</i> (If yes give year or dates of service)				16b. SOCIAL SECURITY NO. <i>none</i>		17. INFORMANT <i>Winnie Spahn</i> Address <i>Edgewood Md</i>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>assault</i> <i>7701</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>premature labor</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>abruptio placentae</i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>7615</i>													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)									
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State			
22a. I certify that (I) (this hospital) attended the deceased from <i>6-12, 1968</i> , to <i>6-12, 1968</i> , that (I) (we) last saw the deceased alive on <i>6-12, 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <i>Charles J. Jones</i> DEGREE								ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (Type)								22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <i>June 13 68</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Bel Air Memorial</i>		23d. LOCATION (City or Town) (County) (State) <i>Bel Air Harford Md</i>							
24. FUNERAL DIRECTOR <i>W. H. Archer</i>				ADDRESS <i>Benson Md 2101</i>		25a. REC'D BY REGISTRAR DATE <i>JUN 18 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Jones</i>					

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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" on the line. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief of Health. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit Health prior to burial, cremation, or removal, and in any event

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
MEDICAL EXAMINER'S CERTIFICATE OF DEATH												
1. DECEASED-NAME (Type or Print) Edw-1 Wright Sechrist						2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month June Day 4 Year 1968			2b. HOUR M			
3. SEX M		4. RACE W		5. DATE OF BIRTH Jan. 11, 1920		6. AGE (In years lost birthday) 48 YRS.		IF UNDER 1 YEAR MONTHS 0 DAYS 0		IF UNDER 24 HRS HOURS 0 MIN. 0		
7a. BIRTHPLACE (State or foreign country) Penna.			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Harford			
10. CITY OR TOWN OF DEATH Bel Air, Md.				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Commercial & Savings Bank				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Banker			12b. KIND OF BUSINESS OR INDUSTRY Banking	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.				13b. COUNTY Harford		13c. CITY OR TOWN Bel Air		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 4 Trenton Lane		
14. FATHER'S NAME First Noah Middle G. Last Sechrist						15. MOTHER'S MAIDEN NAME First Bertha Middle I. Last Arnold						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes						16b. SOCIAL SECURITY NO. WW 11 186-18-9036		17. INFORMANT ADDRESS Bel Air, Md. 4 Trenton Lane				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) G-SW Cerebrum												
955X DUE TO, OR AS A CONSEQUENCE OF												
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF												
(c) DUE TO, OR AS A CONSEQUENCE OF												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) 976X												
19a. DATE OF OPERATION						19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year 6-4-68		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.) Shot self						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> OR NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Commercial & Savings Bank		21f. LOCATION Street or R.F.D. No. Bel Air -		City or Town Bel Air		County Harford		State Md.		
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE Gerard E Palmer						CHIEF MEDICAL EXAMINER <input type="checkbox"/> Bel Air, Md.						
EXAMINER'S NAME (Type) Gerard E Palmer - M						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> 22b. DATE SIGNED 6-4-68						
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, city, town, or county) Bel Air, Maryland 21014												
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE June 7, 1968		23c. NAME OF CEMETERY OR CREMATORY Windsor Union Cemetery				23d. LOCATION (City or Town) (County) (State) Windsor York Pa.		
24. FUNERAL DIRECTOR Joseph William Foster						25a. REC'D BY REGISTRAR JUN 24 1968		25b. REGISTRAR'S SIGNATURE Charles Judge				

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Page 1 of 1
Doc: 002232

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

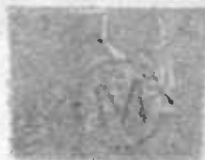
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) First Middle Last JAMES G. SEDERES		2a. DATE OF DEATH Month Day Year June 27 1968		2b. HOUR 5:06 A
3. SEX Male	4. RACE white	5. DATE OF BIRTH 2 October 1896		6. AGE (In years last birthday) 71 YRS.
7a. BIRTHPLACE (State or foreign country) Greece		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
9. COUNTY OF DEATH HARFORD		Md.		
10. CITY OR TOWN OF DEATH HAVER de Grace		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) HARFORD Memorial Hosp.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Cook
12b. KIND OF BUSINESS OR INDUSTRY Restaurant				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND		13b. COUNTY HARFORD	13c. CITY OR TOWN Edgewood	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
13e. STREET AND NUMBER P.O. Box 424				
14. FATHER'S NAME First Middle Last Unknown		15. MOTHER'S MAIDEN NAME First Middle Last Unknown		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service) Yes WW-I		16b. SOCIAL SECURITY NO. 173-03-7710-A		17. INFORMANT Address Steve Karas, Aberdeen, Maryland
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 5719 IMMEDIATE CAUSE (a) Conc. Inj. f. decomp. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) liverthrosis of the liver? DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 5810				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State
22a. I certify that (I) (this hospital) attended the deceased from 6-22- , 19 68 , to 6-27 , 19 68 , that (I) (we) last saw the deceased alive on 6-27 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.				
22b. SIGNATURE I.L. Mezei		DEGREE M.D.		22c. DATE SIGNED 6-27-68
22d. PHYSICIAN'S NAME (Type) I.L. Mezei, M.D.		22e. ADDRESS Havre de Grace, Maryland		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE June 29, 68	23c. NAME OF CEMETERY OR CREMATORY Bakers Cemetery	
23d. LOCATION (City or Town) (County) (State) Aberdeen, (Harford) Maryland				
24. FUNERAL DIRECTOR Hester Macomber Sr.		ADDRESS Aberdeen, Md. 21001		25a. REC'D BY REGISTRAR JUL - 1 1968
25b. REGISTRAR'S SIGNATURE Charles Judge				

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[Faint, mostly illegible text and markings across the page, including what appears to be a large circular stamp in the lower right quadrant.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.)

<div>08524</div> <div> <div>7</div> <div>1</div> </div> <div> <div>08529</div> <div>8</div> </div>													
MIDDLE						LAST			DATE OF DEATH			HOUR	
1. DECEASED-NAME (Type or print) Anne Aloyse Shipley						2a. DATE OF DEATH June 19 1968			2b. HOUR 10P M				
3. SEX Female		4. RACE white		5. DATE OF BIRTH Dec. 27, 1900			6. AGE (In years last birthday) 67 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Harford Md.							
10. CITY OR TOWN OF DEATH Bel Air			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 109 Powell Avenue			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Adm. Assistant			12b. KIND OF BUSINESS OR INDUSTRY U.S. Govt				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) Maryland			13b. COUNTY Harford		13c. CITY OR TOWN Bel Air		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 109 Powell Avenue				
14. FATHER'S NAME First James Middle Whaland Last Whaland					15. MOTHER'S MAIDEN NAME First Johanna Middle Hartigan Last Hartigan								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown no (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. 220-20-7682		17. INFORMANT (husband) Percy B. Shipley			17a. ADDRESS 109 Powell Avenue Bel Air, Md. 21014					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIO-RESP. FAILURE												3 DAYS	
1530 DUE TO, OR AS A CONSEQUENCE OF (b) METASTATIC CARCINOMA												10 MONTHS	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) CARCINOMA OF CECUM												@1 YEAR.	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
1530													
19a. DATE OF OPERATION -			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from June 19 1968 , to June 19 1968 , that (I) (we) last saw the deceased alive on June 19 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE H. Proctor Sidwell M.D. DEGREE M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>												22c. DATE SIGNED June 20, 1968	
22d. PHYSICIAN'S NAME (Type) H. Proctor Sidwell, M.D.						22e. ADDRESS 401 Franklin St., Bel Air, Md. 21014							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE June 22, 1968		23c. NAME OF CEMETERY OR CREMATORY St. Ignatius Cemetery			23d. LOCATION (City or Town) (County) (State) Hickory, Har. Co., Maryland					
24. FUNERAL DIRECTOR Joseph William Foster						W. Broadway & William Bel Air, Maryland 21014			25a. REC'D BY REGISTRAR JUN 21 1968		25b. REGISTRAR'S SIGNATURE Charles Judge		

UNITED STATES OF AMERICA

Dec. 27, 1900

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A 15-72
30M REV. 1-68

<div style="display: flex; justify-content: space-between;"> 08525 MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 08530 </div> <div style="text-align: center; font-weight: bold;">CERTIFICATE OF DEATH</div>																	
1. DECEASED-NAME (Type or print)			First HELEN			Middle M.			Last SMITH			2a. DATE OF DEATH June Month 5 Day 1968			2b. HOUR 4:23 PM		
3. SEX Female			4. RACE Caucasian			5. DATE OF BIRTH April 6, 1921			6. AGE (In years last birthday) 47 YRS.			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (State or foreign country) W. Virginia			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Harford			Md.					
10. CITY OR TOWN OF DEATH Havre de Grace			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Harford Memorial			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Clerk--Typist			12b. KIND OF BUSINESS OR INDUSTRY Hospital								
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. COUNTY Harford			13c. CITY OR TOWN Aberdeen			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET AND NUMBER Route #2, Box 360-D-1					
14. FATHER'S NAME First Middle Last Robert S. Snyder			15. MOTHER'S MAIDEN NAME First Middle Last Viola Robinson														
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, <input type="checkbox"/> No, <input checked="" type="checkbox"/> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. 216-18-1739			17. INFORMANT Lester L. Smith, Aberdeen, Maryland			Address								
18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Liver, Metastatic 174X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of Rt. Breast DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 mos. 20 mos.																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) 170X																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State											
22a. I certify that (I) (this hospital) attended the deceased from 8-25-55 19 55 , to 6-5-68 19 68 , that (I) (we) last saw the deceased alive on 6-5-68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE Peter P. Rodman, M.D.			22c. DATE SIGNED 6-6-68			22d. PHYSICIAN'S NAME (Type) Peter P. Rodman, M.D.			22e. ADDRESS 8 Law Street, Aberdeen, Maryland								
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE 7/June 1968			23c. NAME OF CEMETERY OR CREMATORY Bel Air Memorial Gardens			23d. LOCATION (City or Town) (County) (State) Bel Air, (Harford) Maryland								
24. FUNERAL DIRECTOR John D. Lanning			25a. REC'D BY REGISTRAR Charles Judge			25b. REGISTRAR'S SIGNATURE Charles Judge			DATE JUN 10 1968								

5522

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. at Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

08526

08531

1. DECEASED-NAME (Type or print) <i>HENRY</i> First <i>Timberlake</i> Middle <i>Timberlake</i> Last			2a. DATE OF DEATH Month <i>6</i> Day <i>8</i> Year <i>68</i>		2b. HOUR M
3. SEX <i>male</i>	4. RACE <i>White</i>	5. DATE OF BIRTH <i>05-16-92</i>		6. AGE (In years last birthday) <i>76</i> YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (State or foreign country) <i>Virginia</i>	7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <i>Harford</i> Md.		
10. CITY OR TOWN OF DEATH <i>Harrods Grace, Md.</i>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>St. Elizabeth's Nursing Home</i>	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Toolmaker</i>	12b. KIND OF BUSINESS OR INDUSTRY <i>U.S. Govt. - Ret.</i>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Maryland</i>	13b. COUNTY <i>Harford</i>	13c. CITY OR TOWN <i>Joppa</i>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER <i>23 Fort Hoyle Road</i>	
14. FATHER'S NAME First <i>Harry</i> Middle <i>--</i> Last <i>Timberlake</i>		15. MOTHER'S MAIDEN NAME First <i>Amanda</i> Middle <i>--</i> Last <i>Byrne</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>No</i> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. <i>220-20-7820</i>	17. INFORMANT Address <i>Joppa, Md.</i> <i>Mrs. Hattie G. Timberlake, 23 Fort Hoyle Rd</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>G.I. hemorrhage</i> <i>151.9</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>151.9</i> (b) <i>Ca. of stomach</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>--</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 week</i> <i>4-6 months</i>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>O.A.S. C.V.D. (2) Pneumonitis</i>					
19a. DATE OF OPERATION <i>--</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>--</i>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>--</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <i>--</i>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <i>--</i>	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) <i>--</i>		21f. LOCATION Street or R.F.D. No. City or Town County State <i>--</i>	
22a. I certify that (I) (this hospital) attended the deceased from <i>April 12, 1968</i> to <i>June 8th, 1968</i> , that (I) (we) last saw the deceased alive on <i>June 8th, 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>Edward C. Loo</i>		22c. DATE SIGNED <i>6/8/68</i>		22d. PHYSICIAN'S NAME (Type) <i>Edward C. Loo, M.D.</i>	
22e. ADDRESS <i>Harrods Grace, Md.</i>		22f. ADDRESS <i>Harrods Grace, Md.</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>June 11, 1968</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Mt. Christian Cemetery</i>	
23d. LOCATION (City or Town) (County) (State) <i>Joppa Harford Md</i>		23e. REC'D BY REGISTRAR <i>Charles Judge</i>			
24. FUNERAL DIRECTOR <i>Howard K. McComas & Son, Abingdon, Md.</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A 15 A
30M REV 11-68

M				08527				DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				08532			
1. DECEASED-NAME (Type or print)				First Middle Last				2a. DATE OF DEATH				2b. HOUR			
Mattie G. Tomlinson								Month 6 Day 11 Year 1968				8:30 A			
3. SEX		4. RACE		5. DATE OF BIRTH				6. AGE (In years lost birthday)				IF UNDER 1 YEAR		IF UNDER 24 HRS.	
Female		White		07-24-95				72				MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH						Md.			
Virginia		USA				Harford									
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)				12b. KIND OF BUSINESS OR INDUSTRY			
Havre de grace, MD.				Citizens Nursing Home				Housewife							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER					
Maryland				Harford		Darlington				Rt. #, box 279					
14. FATHER'S NAME First Middle Last				15. MOTHER'S MAIDEN NAME First Middle Last											
William B. St. John				Betty A. Light											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown				16b. SOCIAL SECURITY NO.		17. INFORMANT Address									
No				217-09-1366		Mrs. Leftridge Moxley, Darlington, Md.									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Monocytic Leukemia</u> 2060 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>-</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>-</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 months					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 2042 H.S. C.V.D.															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work or work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State											
22a. I certify that (I) (this hospital) attended the deceased from 5/5/68 to 6/11/68, that (I) (we) last saw the deceased alive on 6/11/68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE <u>Edward C. Loo, M.D.</u>				DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 6/11/68							
22d. PHYSICIAN'S NAME (Type) <u>Edward C. Loo, M.D.</u>				22e. ADDRESS <u>Havre de Grace, Md.</u>											
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City or Town) (County) (State)							
Burial		June 14, 1968		Bel Air Memorial Gardens, Bel Air, Harford Co.											
24. FUNERAL DIRECTOR ADDRESS				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE Md.									
John H. Harkins, Delta, Pa.				DATE JUN 17 1968		<u>Charles Judge</u>									

72280

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers and pages 2 and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 416 (4)
30M REV. 1/58

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print) <i>Ethel</i>			First Middle Last <i>Vicari</i>			2a. DATE OF DEATH Month <i>June</i> Day <i>6</i> Year <i>1968</i>		2b. HOUR <i>10:45</i> PM			
3. SEX <i>Female</i>		4. RACE <i>white</i>		5. DATE OF BIRTH <i>January 20, 1906</i>		6. AGE (In years last birthday) <i>62</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (State or foreign country) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>HARFORD</i> Md.					
10. CITY OR TOWN OF DEATH <i>HAURE de Grace</i>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>HARFORD Memorial Hosp.</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>House-wife</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md.</i>			13b. COUNTY <i>HARFORD</i>		13c. CITY OR TOWN <i>Aberdeen</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>55 Great Oaks Dr.</i>		
14. FATHER'S NAME First <i>Jacob</i> Middle <i>N.</i> Last <i>Browning (D)</i>			15. MOTHER'S MAIDEN NAME First <i>Elsie</i> Middle <i>Pearl</i> Last <i>Arrington (D)</i>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <i>No</i> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. <i>213-18-9243A</i>		17. INFORMANT Address <i>June Sassaman, Aberdeen, Maryland</i>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: <i>4129</i> IMMEDIATE CAUSE (a) <i>arteriosclerotic heart disease</i> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost: <i>4200</i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>> 5 Yrs</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>diphtheria mellitus</i>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from <i>June 1</i> , 19 <i>68</i> , to <i>June 6</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>JUNE 4</i> , 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>B.J. Plunkett Jr.</i> M.D. DEGREE					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED <i>6-7-68</i>			
22d. PHYSICIAN'S NAME (Type) <i>B.J. Plunkett Jr. M.D.</i>					22e. ADDRESS <i>617 W. Bel Air Ave. Aberdeen, Maryland</i>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>9 June 68</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Harford Memorial Gardens</i>		23d. LOCATION (City or Town) (County) (State) <i>Aberdeen (Harford) Maryland</i>					
24. FUNERAL DIRECTOR ADDRESS <i>Tarring Funeral Home, Aberdeen, Maryland 21001</i>					25a. REC'D BY REGISTRAR DATE <i>SUN 11 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 15 (4)
30M REV. 1-68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
<div style="display: flex; justify-content: space-between;"> 08529 CERTIFICATE OF DEATH 08534 </div>												
1. DECEASED-NAME (Type or print)			First		Middle		Last		2a. DATE OF DEATH		2b. HOUR	
Ella			B.		Ward				6 Month 14 Day 68 Year		3:20 PM	
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS	
F			W			03/27/89			79 YRS.			
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH			
Maryland			U.S.A.						Harford Md.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY			
Havre de Grace			Citizens Nursing Home			Homemaker						
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Md.			Harford			Havre de Grace					627 Stokes St.	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME									
Charles F Barnard			Eleanor Taylor									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT				Address		
No			212-52-8663			Miss Samuel Lunn				306 Babylon St. Harford, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART I. DEATH WAS CAUSED BY:												
IMMEDIATE CAUSE (a) 1829 Cardiac Insufficiency												
DUE TO, OR AS A CONSEQUENCE OF (b) General debility - multiple CA												
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 1748 (c)												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
Operated 10 years ago - CA uterus (Dr. Mark)												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from 4-3, 1964, to 6-16, 1968, that (I) (we) last saw the deceased alive on 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.												
22b. SIGNATURE			22c. DATE SIGNED									
A. L. LEWIS MD			6/18/68									
22d. PHYSICIAN'S NAME (Type)			22e. ADDRESS									
A. L. LEWIS MD												
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)			
Burial			6/18/68			Angel Hill			Harford, Md.			
24. FUNERAL DIRECTOR			25a. REC'D BY REGISTRAR			25b. REGISTERED SIGNATURE						
Funerary Co., Harford, Md.			DATE JUN 19 1968									

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15-1
30M REV. 1/68

08530

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Items 7a, B, Film G401 6/17/68 km

CERTIFICATE OF DEATH

08535

1. DECEASED-NAME (Type or print) First Roy Middle James Last Ward.			2a. DATE OF DEATH Month 6 Day 6 Year 1968			2b. HOUR - 6:45 PM					
3. SEX Male		4. RACE White		5. DATE OF BIRTH Aug 12 - 1906		6. AGE (In years lost birthday) 61 YRS.		IF UNDER 1 YEAR MONTHS 0 DAYS 0 HOURS 0 MIN.		IF UNDER 24 HRS. HOURS 0 MIN.	
7a. BIRTHPLACE (State or foreign country) West Chester, Pa		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Harford Md.					
10. CITY OR TOWN OF DEATH Three-de-Grace			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Harford Memorial Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.			13b. COUNTY Harford		13c. CITY OR TOWN Three-de-Grace		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 612 Pearl St		
14. FATHER'S NAME First John W. Middle Ward Last			15. MOTHER'S MAIDEN NAME First Vera Middle Robinson Last								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No			16b. SOCIAL SECURITY NO. unk		17. INFORMANT Mary F. Ward (Wife)			Address same as above			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) massive coronary thrombosis 2509 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Angina DUE TO, OR AS A CONSEQUENCE OF (c) Diabetes mellitus APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 yrs 2 yrs											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 260x											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from June 6, 1968 , to June 6, 1968 , that (I) (we) last saw the deceased alive on June 6, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Edward J. Simon						DEGREE MD ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 6-6-68			
22d. PHYSICIAN'S NAME (Type) EDWARD J. SIMON						22e. ADDRESS Harford General Hospital, Md					
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE 6/10/68		23c. NAME OF CEMETERY OR CREMATORY Mt. Eden		23d. LOCATION (City or Town) (County) (State) Harford General Md				
24. FUNERAL DIRECTOR Carrollton Lee Howard Shaw, Md.						ADDRESS		25a. REC'D BY REGISTRAR DATE JUN 11 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	

08280

1832

OFFICE OF DEATH

636-1-190

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (Rev. 1-68)

08531		MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				08536	
CERTIFICATE OF DEATH							
1. DECEASED-NAME (Type or print) <i>Verlie</i> First <i>Wing</i> Last			2a. DATE OF DEATH Month <i>6</i> Day <i>17</i> Year <i>68</i>			2b. HOUR <i>3:28</i> AM	
3. SEX <i>Female</i>		4. RACE <i>Col.</i>		5. DATE OF BIRTH <i>Feb. 11, 1884</i>		6. AGE (In years last birthday) <i>84</i> YRS. IF UNDER 1 YEAR MONTHS <i>4</i> DAYS <i>6</i> IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <i>MARYLAND</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>HARFORD</i> Md.	
10. CITY OR TOWN OF DEATH <i>HARFORD</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Harford Memorial Hosp</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Housewife</i>	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <i>Md.</i>		13b. COUNTY <i>Harford</i>		13c. CITY OR TOWN <i>Harford</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME First <i>George</i> Middle <i>Hill</i> Last <i>Ellis</i>		15. MOTHER'S MAIDEN NAME First <i>Rosana</i> Middle <i>Ellis</i> Last <i>Ellis</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or unknown) <i>no</i> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. <i>220-03-2481</i>		17. INFORMANT Address <i>Miss. Millicent E. Wing - Harford Grace</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Broncho Pneumonia</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>CVA</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>CVA</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>5 days</i> <i>15 days</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>331X</i>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <i>6-17-68</i> , 19 <i>68</i> , to <i>6-17</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>6-17-68</i> , 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Edward J. Simon</i> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22c. DATE SIGNED <i>6-18-68</i>			
22d. PHYSICIAN'S NAME (Type) <i>EDWARD J. SIMON</i>				22e. ADDRESS <i>HARFORD GRACE</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>6-20-68</i>		23c. NAME OF CEMETERY OR CREMATORY <i>St. James A.M.E. Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Harford Grace Harford, Md.</i>	
24. FUNERAL DIRECTOR <i>Otelis J. Bullock, Harford Grace, Md.</i> ADDRESS				25a. REC'D BY REGISTRAR <i>J. Charles Judge</i> DATE <i>JUN 24 1968</i>		25b. REGISTRAR'S SIGNATURE	

22220

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

MDARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

08532

08537

1. DECEASED-NAME (Type or print) Samuel Hamilton Woods			2a. DATE OF DEATH Month 6 Day 2 Year 68			2b. HOUR 9:35 PM				
3. SEX Male		4. RACE White		5. DATE OF BIRTH June 13th 1881		6. AGE (In years last birthday) 87 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) N.Y.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Hartford Md.				
10. CITY OR TOWN OF DEATH Hartford			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Hartford Memorial Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md		13b. COUNTY Hartford		13c. CITY OR TOWN Aberdeen		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER R.D.#2 Box 104		
14. FATHER'S NAME First Middle Last John H. Woods			15. MOTHER'S MAIDEN NAME First Middle Last Sarah Heatherly							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) Yes (If yes give war or dates of service) WW-I		16b. SOCIAL SECURITY NO. 220-22-0614		17. INFORMANT Mildred B. Ruppel,			Address Aberdeen, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia. 486X DUE TO, OR AS A CONSEQUENCE OF (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 486X										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 6-2-68 , 19 68 , to 6-2-68 , 19 68 , that (I) (we) last saw the deceased alive on 6-2-68 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Lajos I. Mezei					DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 6/2/68			
22d. PHYSICIAN'S NAME (Type) Lajos I. Mezei, M.D.					22e. ADDRESS 601 S. Union Ave. Havre de Grace, Md. 21078					
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 7 June 1968		23c. NAME OF CEMETERY OR CREMATORY Laurel Grove Cemetery		23d. LOCATION (City or Town) (County) (State) Port Jervis, New York				
24. FUNERAL DIRECTOR John Macomber Sr.					Tarring Funeral Home Aberdeen, Md. 21001		25a. REC'D BY REGISTRAR JUN 7 1968		25b. REGISTRAR'S SIGNATURE James J. Jones	

22130

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1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 100. 101. 102. 103. 104. 105. 106. 107. 108. 109. 110. 111. 112. 113. 114. 115. 116. 117. 118. 119. 120. 121. 122. 123. 124. 125. 126. 127. 128. 129. 130. 131. 132. 133. 134. 135. 136. 137. 138. 139. 140. 141. 142. 143. 144. 145. 146. 147. 148. 149. 150. 151. 152. 153. 154. 155. 156. 157. 158. 159. 160. 161. 162. 163. 164. 165. 166. 167. 168. 169. 170. 171. 172. 173. 174. 175. 176. 177. 178. 179. 180. 181. 182. 183. 184. 185. 186. 187. 188. 189. 190. 191. 192. 193. 194. 195. 196. 197. 198. 199. 200. 201. 202. 203. 204. 205. 206. 207. 208. 209. 210. 211. 212. 213. 214. 215. 216. 217. 218. 219. 220. 221. 222. 223. 224. 225. 226. 227. 228. 229. 230. 231. 232. 233. 234. 235. 236. 237. 238. 239. 240. 241. 242. 243. 244. 245. 246. 247. 248. 249. 250. 251. 252. 253. 254. 255. 256. 257. 258. 259. 260. 261. 262. 263. 264. 265. 266. 267. 268. 269. 270. 271. 272. 273. 274. 275. 276. 277. 278. 279. 280. 281. 282. 283. 284. 285. 286. 287. 288. 289. 290. 291. 292. 293. 294. 295. 296. 297. 298. 299. 300. 301. 302. 303. 304. 305. 306. 307. 308. 309. 310. 311. 312. 313. 314. 315. 316. 317. 318. 319. 320. 321. 322. 323. 324. 325. 326. 327. 328. 329. 330. 331. 332. 333. 334. 335. 336. 337. 338. 339. 340. 341. 342. 343. 344. 345. 346. 347. 348. 349. 350. 351. 352. 353. 354. 355. 356. 357. 358. 359. 360. 361. 362. 363. 364. 365. 366. 367. 368. 369. 370. 371. 372. 373. 374. 375. 376. 377. 378. 379. 380. 381. 382. 383. 384. 385. 386. 387. 388. 389. 390. 391. 392. 393. 394. 395. 396. 397. 398. 399. 400. 401. 402. 403. 404. 405. 406. 407. 408. 409. 410. 411. 412. 413. 414. 415. 416. 417. 418. 419. 420. 421. 422. 423. 424. 425. 426. 427. 428. 429. 430. 431. 432. 433. 434. 435. 436. 437. 438. 439. 440. 441. 442. 443. 444. 445. 446. 447. 448. 449. 450. 451. 452. 453. 454. 455. 456. 457. 458. 459. 460. 461. 462. 463. 464. 465. 466. 467. 468. 469. 470. 471. 472. 473. 474. 475. 476. 477. 478. 479. 480. 481. 482. 483. 484. 485. 486. 487. 488. 489. 490. 491. 492. 493. 494. 495. 496. 497. 498. 499. 500. 501. 502. 503. 504. 505. 506. 507. 508. 509. 510. 511. 512. 513. 514. 515. 516. 517. 518. 519. 520. 521. 522. 523. 524. 525. 526. 527. 528. 529. 530. 531. 532. 533. 534. 535. 536. 537. 538. 539. 540. 541. 542. 543. 544. 545. 546. 547. 548. 549. 550. 551. 552. 553. 554. 555. 556. 557. 558. 559. 560. 561. 562. 563. 564. 565. 566. 567. 568. 569. 570. 571. 572. 573. 574. 575. 576. 577. 578. 579. 580. 581. 582. 583. 584. 585. 586. 587. 588. 589. 590. 591. 592. 593. 594. 595. 596. 597. 598. 599. 600. 601. 602. 603. 604. 605. 606. 607. 608. 609. 610. 611. 612. 613. 614. 615. 616. 617. 618. 619. 620. 621. 622. 623. 624. 625. 626. 627. 628. 629. 630. 631. 632. 633. 634. 635. 636. 637. 638. 639. 640. 641. 642. 643. 644. 645. 646. 647. 648. 649. 650. 651. 652. 653. 654. 655. 656. 657. 658. 659. 660. 661. 662. 663. 664. 665. 666. 667. 668. 669. 670. 671. 672. 673. 674. 675. 676. 677. 678. 679. 680. 681. 682. 683. 684. 685. 686. 687. 688. 689. 690. 691. 692. 693. 694. 695. 696. 697. 698. 699. 700. 701. 702. 703. 704. 705. 706. 707. 708. 709. 710. 711. 712. 713. 714. 715. 716. 717. 718. 719. 720. 721. 722. 723. 724. 725. 726. 727. 728. 729. 730. 731. 732. 733. 734. 735. 736. 737. 738. 739. 740. 741. 742. 743. 744. 745. 746. 747. 748. 749. 750. 751. 752. 753. 754. 755. 756. 757. 758. 759. 760. 761. 762. 763. 764. 765. 766. 767. 768. 769. 770. 771. 772. 773. 774. 775. 776. 777. 778. 779. 780. 781. 782. 783. 784. 785. 786. 787. 788. 789. 790. 791. 792. 793. 794. 795. 796. 797. 798. 799. 800. 801. 802. 803. 804. 805. 806. 807. 808. 809. 810. 811. 812. 813. 814. 815. 816. 817. 818. 819. 820. 821. 822. 823. 824. 825. 826. 827. 828. 829. 830. 831. 832. 833. 834. 835. 836. 837. 838. 839. 840. 84

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